

Health Insurance 2016



Open Enrollment Summary for retirees

Exclusive Retiree Meetings

Open meetings, no need to register

October 27, 2015, 10:00 a.m. - 12:00 noon - MnDOT
2151 Bassett Drive, Mankato 56001

October 28, 2015, 10:00 a.m. - 12:00 noon - MSRS
60 Empire Drive, St. Paul 55103

October 29, 2015, 1:00 p.m. - 3:00 p.m. – Rochester Library
101 Second Street SE, Rochester, MN 55904

October 30, 2015, 10:00 a.m. - 12:00 noon – Southdale Library
7001 York Avenue S, Edina 55435

November 2, 2015, 10:00 a.m. – 12:00 noon - MSRS
60 Empire Drive St. Paul, MN 55103

November 3, 2015, 10:00 a.m. - 12:00 noon – Brainerd Fire Dept.
23 Laurel Street, Brainerd, MN 56401

November 4, 2015, 10:00 a.m. - 12:00 noon – MnDOT
1123 Mesaba Avenue, Duluth, MN 55811

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Open Enrollment for Retirees

- Open Enrollment is held from **October 27 - November 9, 2015**.
- Retirees may change carriers.
- The BlueCross BlueShield Coordinated Plan will increase premiums by 9.26%.
- HealthPartners Freedom Plan will increase premiums by 7.21%.
- UCare for Seniors premiums will increase by 2.53%.
- The Minnesota Advantage Plan premiums will increase by 7.4%.

Steps for a successful Open Enrollment

1. Carefully review the information in this booklet.

Changes in the Minnesota Advantage Plan and Senior Plans for the plan year 2016 are highlighted in this booklet and posted on the SEGIP website at: mn.gov/mmb/segip.

2. Review the plan availability in this booklet on page 10.

This will tell you which health plans are available to you. You may choose any plan available in the county in which you live.

3. Review the 2016 insurance rate table on page 11 of this booklet.

It lists the premium costs for each of the state's health plans.

4. Check your Advantage Health Plan Primary Care Clinic (PCC) to ensure participation for Plan year 2016. Some clinics have changed cost levels.

There are changes in Primary Care Clinic Cost Levels for the Minnesota Advantage Health Plan. The same clinic can be listed as a different cost level depending on the carrier selected. A list of participating clinics is available on the SEGIP website at: mn.gov/mmb/segip. To access, click on the Open Enrollment tab. If you want to keep your current health carrier, but change clinics, call your carrier using the phone number listed on page 23 of this booklet. If you want to change health carriers, you must complete and return **both** Open Enrollment forms at the back of this booklet by November 9, 2015.

5. Complete and mail your applications if you want to make changes.

Complete the application and disenrollment forms in this booklet and mail them to the appropriate carrier listed on page 23. If enrolling in senior plans, you will receive additional enrollment forms from your new carrier at your home address. These must also be completed and returned to your new carrier as quickly as possible (prior to December 31, 2015).

Open Enrollment applications must be postmarked by November 9, 2015.

If you do not want to make changes, you do not have to complete the application.

Gathering Open Enrollment Information

- **Employee and Retiree meetings.** Employee meetings will be held in selected locations throughout Minnesota. For information on general Open Enrollment meeting times and locations, consult the SEGIP website available at: mn.gov/mmb/segip. Retiree Open Enrollment meetings will be held on selected days, October 27 through November 4, 2015. Details about the retiree meetings can also be found on the Minnesota Retired State Employees Association (MRSEA) website at: www.mrsea.org and the SEGIP website. **There is no need to register to attend the retiree meetings.** Questions about the retiree meetings should be directed to SEGIP at: 651-355-0100 or 1-800-664-3597.
- **Via the Internet.** The State Employee Group Insurance Program (SEGIP) has its own website. This site has a special Open Enrollment tab. The SEGIP website provides links to the provider directories published by the three Minnesota Advantage Health Plan Claims Administrators (carriers): BlueCross BlueShield, HealthPartners, and PreferredOne. Lists of participating doctors and clinics are accessible through the Minnesota Advantage Health Plan to help you make your Primary Care Clinic (PCC) selection. This list also includes the PCC's number that you will need to write on your form in order to enroll. Each carrier has a unique number for the PCCs. The list is on the SEGIP website at: mn.gov/mmb/segip. To access, click on the Open Enrollment tab.
- **Via the phone.** You may call the carriers directly if you have specific questions or to request a plan's area provider list. Each health insurance carrier will provide a list of its participating clinics specific to your area and clinic numbers for Advantage, UCare for Seniors, HealthPartners Freedom Plan, and the BlueCross BlueShield Coordinated Plan will provide directories for the plans to members age 65 and over. The carriers' phone numbers are listed on page 23 of this booklet.
- **SEGIP's Open Enrollment Service Center.** For answers to questions about rates, eligibility, and coverage or for help with enrollment issues call SEGIP's Open Enrollment Service Center for assistance through November 9, 2015. SEGIP representatives are available Monday through Friday from 8:00 a.m. to 4:00 p.m. Call 651-355-0100 or 1-800-664-3597 in greater Minnesota. Consumers with hearing or speech disabilities may contact SEGIP via their preferred Telecommunications Relay Service.

An overview of your health benefits

As a state retiree who elected to continue coverage, you and your eligible dependents are entitled to receive health insurance benefits through the State Employee Group Insurance Program (SEGIP).

Open Enrollment will be held from October 27 – November 9, 2015. This booklet is designed to help you make decisions about the SEGIP health benefits that you will receive during the 2016 plan year. Use it to learn about the Minnesota Advantage Health Plan changes and where to find additional information on changes for 2016. Changes in Senior Plans and costs which may impact your selection of health plans are listed in the back of this booklet. After Open Enrollment, you are encouraged to keep this booklet for the remainder of the new plan year as a reference guide. Use it in conjunction with your Plan Summary or Certificate of Coverage to gain a greater understanding of your benefits.

For information about Open Enrollment, state retirees may view information on the SEGIP website at: mn.gov/mmb/segip or call:

Employee Insurance Division/SEGIP 651-355-0100; 800-664-3597

Consumers with hearing or speech disabilities may contact us via their preferred Telecommunications Relay Service.

The Employee Insurance Division, in partnership with the Minnesota Retired State Employees' Association (MRSEA), will hold exclusive Retiree Open Enrollment meetings. Check the front cover or page 24 of this booklet for locations and times. **You do not need to register to attend a retiree meeting.** Presentations will be given during the first hour. The second hour provides retirees with a chance to speak with individual carriers and gather information. Please note, meetings may end early if attendance dictates. Retiree meetings are also listed on the SEGIP website at: mn.gov/mmb/segip and the MRSEA website at: www.mrsea.org.

Medicare Part D (Prescription Drug Coverage)

CAUTION: Members enrolling in the age 65 and over plans (Senior Plans) should NOT apply for or purchase Medicare Part D from another Part D carrier for prescription drug coverage.

Enrolling in Part D with an insurance company that is different from your SEGIP group carrier will terminate participation in the state's senior plans. As you approach age 65, Medicare beneficiaries will see marketing materials from several different insurance companies and pharmacies offering prescription coverage. If you purchase that coverage, you will **permanently lose** medical insurance coverage in the state's retiree group.

If you attain age 65 and enroll in Medicare Parts A and B while you are participating in SEGIP as a retiree, your enrollment in Medicare Part D will be handled by enrolling with your carrier's Senior Plan (BlueCross BlueShield participants enroll in the Coordinated Plan, HealthPartners participants enroll in HealthPartners Freedom Plan and PreferredOne participants enroll in UCare for Seniors).

Retirees under age 65 in the Minnesota Advantage Health Plan have existing prescription drug coverage through Navitus that, on average is as good as if not better than Medicare Part D. This is important. It ensures that you will not be penalized with a higher premium or Part D penalty if you join a Medicare prescription plan after Medicare Part D was first made available to you. A disclosure is available on the SEGIP website.

SEGIP Plan Benefit: The pharmacy benefit of the Senior Plans will include and coordinate with Medicare Part D. Participants in the Senior Plans do not pay a separate Part D premium to Medicare or to a Part D carrier. The Medicare Part D benefit and premium are built into the premium paid directly to BlueCross BlueShield Coordinated Plan, HealthPartners Freedom Plan, and UCare for Seniors.

Enrollment: New members to any of the Senior Plans that coordinate with Medicare must immediately complete the Senior Plan's enrollment form and Medicare Part D form sent to their home address by the health plan or carrier. Participants who turn 65 during the year and continue coverage in SEGIP must also complete and return both the senior plan enrollment form and the Medicare Part D form prior to the month in which they turn 65 to ensure timely coverage upon turning age 65.

Premiums

The premiums for the Minnesota Advantage Health Plan will increase by 7.4%.

The 2016 Senior Plans will experience increases in premium rates. The Coordinated Plan offered by BlueCross BlueShield will increase its premium to \$295.00 per month. The HealthPartners Freedom Plan will also increase its premium to \$272.10 per month. UCare for Seniors will increase to \$284.00 per month.

What's New

New Advantage Plan Benefit:

Palliative Care is added as a new benefit to the Minnesota Advantage Plan. There are also expanded benefits for Intensive Behavioral Therapies for dependents with Autism Spectrum Disorders. Participants seeking information or coverage under these two areas should contact their PCC or carrier for details about referrals, covered providers, and covered services.

The cost of health care continues to rise. To deal with these economic pressures the Advantage Plan will increase some of the plan's cost sharing features. Review the Schedule of Benefits to see the changes to the first dollar deductibles across all cost levels, copays and out-of-pocket maximums. More information is available on the next page under Cost Sharing Changes.

The Minnesota Advantage Health Plan

Minnesota Advantage Health Plan benefit changes

The cost sharing features, such as deductibles, copays, and coinsurance will change for Plan year 2016.

Cost Sharing Changes

As the cost of health care continues to rise, reasonable premiums can be sustained with the introduction of increased cost sharing. The out-of-pocket maximums across all cost levels will increase by \$100 for single and \$200 for family. The plan out-of-pocket maximums will help protect members from experiencing sudden, high expenses. Changes to cost sharing appear in three additional areas. The first dollar deductibles have increased, as well as office visit copays, and the prescription drug copays. Please review the Schedule of Benefits page 15 for changes to the first dollar deductibles and office visit copays. Although the prescription drug out-of-pocket maximum will remain at \$800 for single and \$1600 for family, the copays will increase to \$14.00 for Tier I, \$25.00 for Tier II, and \$50.00 for Tier III. Remember, Navitus offers a mail order program for certain maintenance medications, providing a 90-day supply for only two copays, as apposed to three.

Office visit copayments

The Advantage Summary lists two copay amounts for office visits in all cost levels. Active employees may complete the StayWell health assessment and agree to a follow-up health call to receive the lower office visit copay. The personal health assessment **is not available to retirees who pay their premiums directly to the carrier**. Because you do not have access to the health assessment, you will automatically pay the lower copay amount. For example, the copayment in cost level 2 lists \$30 and \$35 copays. You will pay \$30 after the annual deductible is satisfied.

Retirees who pay all or a portion of their medical insurance premium to SEGIP or MMB are required to take the assessment and agree to accept a health call from StayWell to receive the lower copay. The health assessment can be accessed directly at: SEGIP.staywell.com. Participants who receive an employer contribution to their coverage will need to use their new Retiree ID number to access StayWell. If this is your first year as a Retiree, you may need to set up a new account using your new Retiree ID number. This process must be completed during the Open Enrollment period of October 27 – November 9, 2015.

Primary Care Clinics and Provider Quality

There are many changes to Primary Care Clinic Cost levels. Check your current Primary Care Clinic's Cost level at mn.gov.mmb/segip on the Open Enrollment tab. Quality of care information will be provided through Minnesota HealthScores for most of Minnesota's Primary Care Clinics (PCC) on the website. Minnesota HealthScores is a nonprofit organization that monitors and reports how well physician groups deliver preventive care and manage a variety of health conditions.

Access to this information is provided via a direct link from the clinic listings in our Minnesota Advantage Health Plan on-line provider directory to the corresponding quality ratings on MN HealthScores' website. Before you make or change your provider selection, be sure to review the quality ratings from MN HealthScores.

Enrolling

If you or your spouse will be turning age 65 during 2016, you should also review the Senior Plans. The Advantage Plan carrier that you have in place when you turn age 65 determines the Senior Plan that you will be eligible to enroll with for the remainder of the 2016 plan year. Turning age 65 and becoming eligible for Medicare does not give you an opportunity to switch carriers to access a senior plan affiliated with a different carrier.

Check with your carrier during Open Enrollment to see if your provider will participate in the carrier's provider network for the new insurance year. The clinic directories for the Minnesota Advantage Health Plan are available on the SEGIP website. **If under age 65, you may also want to confirm the cost level of your Advantage Health PCC for the upcoming year, as there are changes to the 2016 Clinic Cost Levels.**

If your current clinic will be available to you through SEGIP in 2016, and you do not want to change carriers, you do not need to do anything during this Open Enrollment period. You will continue to participate with your current carrier in 2016.

During Open Enrollment you may change your health carrier. **Any change you make to your health insurance coverage will be effective January 1, 2016 through December 31, 2016. Until then, your current coverage remains in effect provided all premiums are paid through December 31, 2015.**

Other Enrollment Notes

- **Medicare participation.** When you enroll in a new plan you will be asked if you are also enrolled in Medicare Parts A and B. You must be enrolled and provide this information to ensure claims will be processed correctly. If you are changing carriers and are age 65 or greater, you must enroll with the new plan's Part D benefit. The plan will send you Medicare enrollment forms that must be completed immediately to ensure that your new Senior Plan enrollment takes effect January 1, 2016.
- The insurance carrier you enroll with for 2016 will send plan membership cards to your home. PreferredOne will only send cards to new members or members who have a change in the cost level of their PCC. Check your membership cards closely to ensure that all information is correct. If there are errors, call your carrier immediately.
- Advantage Health Plan members will not receive a new Navitus prescription card. Members should continue to use their current Navitus card in the new plan year.
- Remember to fill out a disenrollment form (page 31) for your current plan, if you are switching carriers during this Open Enrollment.

Health Plans offered

- **BlueCross BlueShield Plans**

- Minnesota Advantage Health Plan – BlueCross BlueShield (under age 65)
- Coordinated Plan (age 65 and over and a Medicare Enrollee)

- **HealthPartners Plans**

- Minnesota Advantage Health Plan – HealthPartners (under age 65)
- HealthPartners Freedom Plan (age 65 or over and a Medicare Enrollee)

- **PreferredOne Plans**

- Minnesota Advantage Health Plan – PreferredOne (under age 65)
- UCare for Seniors (age 65 or over and a Medicare Enrollee)

You may receive information about other plans offered by some of the same insurance companies or carriers that offer the plans we just listed. Be cautious. Plans not listed in this book are not state-sponsored. If you enroll in a plan that is not state-sponsored, you forfeit your membership in the State Employee Group Insurance Program (SEGIP) and will never be able to re-enroll in the state group medical insurance.

Please note that if you and your dependents are all under age 65, you must all enroll in the same plan with the same insurance carrier. If you and your spouse or dependents are in different age groups (one is age 65 or older; one is under age 65) or you have other insurance-eligible dependents under age 65, you must select plans appropriate by age group. Both age appropriate plans must be offered by the same insurance carrier.

You may only change carriers during Open Enrollment. Upon turning age 65, you will have the opportunity to enroll in the Senior Plan affiliated with your current Advantage Plan carrier. Those approaching age 65 should receive an enrollment packet for the Senior Plan affiliated with their current carrier the month prior to the month in which they reach age 65.

Cost

You pay the full cost of retiree health coverage for yourself and your insurance eligible dependents. Since you are a member of the State Employee Group Insurance Program (SEGIP), you receive the advantage of lower group rates for high quality plans. This makes your health care coverage more affordable for a very comprehensive plan than if you were to purchase similar coverage on your own. Your monthly cost varies depending on which plan you choose and whether you cover your spouse, the age of your spouse, and whether you cover other eligible dependents. The Minnesota Advantage Health Plan rates and Senior Plan rates are listed in the table on page 11.

Eligibility

If you and/or your spouse are Medicare-eligible and age 65 or older, you must be enrolled in Medicare Part A (hospital insurance) and Part B (supplemental medical insurance). Your Part D (prescription drug coverage) is included with your state group carrier and enrollment will be coordinated through your SEGIP Senior Plan for those age 65 and over.

Participants in the state's retiree health insurance program may change carriers during the annual Open Enrollment period. It is important for you to carefully consider your option to continue your state-sponsored health insurance. If you turn 65 during 2016 you will be offered enrollment in the senior plan affiliated with your current Advantage Plan insurance carrier. **If you decide not to continue, you and/or your dependents may never re-enroll in the state's health plans.**

Family coverage

When you retired and became eligible to maintain your participation in SEGIP's Retiree Plans, your eligible dependents were also able to maintain their coverage.

If you chose coverage for yourself but not your dependent(s) when you retired, you may still be able to add your dependent(s) later. You may add dependent coverage if your eligible dependents, including your spouse: 1.) lose other group coverage or 2.) if you marry after retirement.

At either time, **you must submit a Basic Application to the Employee Insurance Division** of SEGIP, within 30 days of the event. A marriage certificate and other documents will be required to verify the marriage date. When losing other group coverage, you must send written verification from your dependent's employer stating the exact date on which the group coverage will be lost or was lost. Adding new dependents will require that you verify dependent status. The policy holder verifies dependent status for newly added dependents by submitting specific documents. Failure to provide documentation will result in removal of coverage.

Surviving spouses

A spouse who was covered by the state's retiree plans at the time of the retiree's death may continue participation in SEGIP indefinitely.

- **COBRA Qualified Events** – Dependent

If you have maintained coverage for a dependent child who reaches age 26, contact SEGIP prior to their 26th birthday to ensure that a COBRA offer will be provided to your dependent. Additionally, if you divorce after retirement, contact SEGIP to provide this information and inquire about continuation options within 60 days of the divorce.

Important Plan notes

- The state expects to continue the State Employee Group Insurance Program indefinitely. However, the state reserves the right to change or discontinue all or any part of the program consistent with the state's rights and obligations under law and collective bargaining agreements.
- The Plan assumes fraud or intentional misrepresentation if a participant enrolls a dependent who does not meet the Plan's definition of dependent. Upon 30-day notice, coverage will be rescinded to the effective date of coverage. You may be liable for all claims paid by the Plan on behalf of an ineligible dependent.

Availability by county

The Minnesota Advantage Health Plan is available in all Minnesota counties. However, the availability under each carrier may differ slightly. BlueCross BlueShield and HealthPartners offer the Advantage Plan in all Minnesota counties. PreferredOne offers the Minnesota Advantage Health Plan in most Minnesota counties, except Houston County. PreferredOne does not have coverage in Houston County.

Each carrier offering the Minnesota Advantage Health Plan also provides a National Preferred Provider Organization (PPO) for members who permanently reside outside the state and service area (bordering counties) of Minnesota. Contact your carrier, if you need access to Point of Service (POS) benefits for PPO providers, as not all carriers offer PPOs in every state. You must provide your permanent address and request access to this benefit before it is provided.

All three Senior Plans are available in all Minnesota counties. The HealthPartners Freedom Plan and UCare for Seniors also offer coverage in some of the bordering counties of Wisconsin (refer to the Wisconsin counties below). For members age 65 and greater who live outside the state of Minnesota and outside the eligible border counties of Wisconsin, the BlueCross BlueShield Coordinated Plan can provide your coverage. **The Coordinated Plan is the only senior plan available to members whose permanent residence is outside the state of Minnesota and the surrounding Wisconsin counties.**

HealthPartners Freedom Plan Wisconsin Counties	UCare for Seniors Wisconsin Counties	
Barron	Ashland	Juneau
Burnett	Barron	La Crosse
Douglas	Bayfield	Monroe
Dunn	Buffalo	Pepin
Pierce	Burnett	Pierce
Polk	Chippewa	Polk
St. Croix	Crawford	Richland
Washburn	Douglas	Sawyer
	Dunn Eau	Sauk
	Claire	St. Croix
	Grant	Trempealeau
	Iowa	Vernon
	Jackson	Washburn

2016 Monthly Rates	Section 1		Section 2					Section 3			
	Retiree under 65	Retiree 65 & over	Spouse under 65	Spouse under 65 and 1 or more children	One or more eligible child/ no spouse	Spouse 65 & over	Spouse 65 or over and 1 or more children	Surviving Spouse or one dependent under 65	Surviving Spouse 65 and over	Two or more surviving dependents under 65	Surviving Spouse 65 & over and one or more dependent
Minnesota Advantage Health Plan - BlueCross BlueShield Coordinated Plan	564.22 —	— 295.00	1094.98 —	1094.98 —	1094.98 —	— 295.00	1094.98 —	564.22 —	— 295.00	1659.20 —	— 1389.98
	564.22 —	— 272.10	1094.98 —	1094.98 —	1094.98 —	— 272.10	1094.98 —	564.22 —	— 272.10	1659.20 —	— 1367.08
Minnesota Advantage Health Plan - PreferredOne UCare for Seniors	564.22 —	— 284.00	1094.98 —	1094.98 —	1094.98 —	— 284.00	1094.98 —	564.22 —	— 284.00	1659.20 —	— 1378.98

Note: For retirees who wish to cover their families, the amount you pay is the total of the rate for yourself, under the "Section 1" heading, plus the appropriate rate under the "Section 2" heading. For survivors of retirees, choose the appropriate rate under the "Section 3" heading. Rates are subject to change on January 1, 2016.

Plan Summaries

The next section of this booklet provides summaries of each SEGIP health plan offered to retirees.

- Retirees and dependents under age 65 should refer to pages 13 through 15 for plan features and types of services covered under the Minnesota Advantage Health Plan.
- Retirees and/or dependents age 65 and over who are Medicare eligible will find plan summaries and a comparison chart on pages 16 through 22.
- For definitions of some of the terms used in these descriptions, refer to the glossary on pages 25 through 27.

This booklet does not describe the many procedures and requirements established by the carriers to ensure quality and efficiency. For example, this booklet may state that coverage is 100 percent for a certain service, but coverage may also require the carrier's prior approval. You should become familiar with how your plan works in addition to its benefit levels and provider network. Each plan's Certificate of Coverage or Summary of Benefits describes these features. The Minnesota Advantage Health Plan Summary will be available on the SEGIP website. The age 65 and over plan certificates will be mailed to members after January 1, 2016 and will also be made available on the SEGIP website. Click on the purple Medical & Dental tab, then select Retirees. Click on Map your Retiree Benefits and you will find the Summary & Certificates under Medical and Dental Booklets.

Provider Networks

Most health plans have a network of physicians, hospitals, and other health care providers through which you receive your care. To be sure that a particular doctor or other health care provider will be in your plan's network for the 2016 insurance year, call the plan's customer service number (see page 23).

Medicare Coordination

All SEGIP Senior Plans are coordinated with Medicare Parts A, B, and D for people age 65 and older. Medicare-eligible retirees and spouses age 65 and older are required to enroll in Medicare Part A (hospital insurance) and Part B (supplemental medical insurance) in order to participate in the state's group insurance plans. Enrollment in Medicare Part D (prescription drugs) is included with the state group carrier you have chosen for all medical benefits. Your enrollment in Part D will be coordinated through the carrier with which you participate.

Important note

The following descriptions are meant only to highlight the benefits provided by each plan. Please refer to the Certificate of Coverage or Summary of Benefits for complete descriptions of all benefits and exclusions. If there are differences between this document and the plans' Certificates of Coverage or Summary of Benefits, the Certificates of Coverage or Summary of Benefits will govern.

Minnesota Advantage Health Plan (under age 65)

Minnesota Advantage Health Plan is the medical benefits program for all retirees and dependents under age 65

All state of Minnesota retirees and eligible dependents under age 65 who receive medical coverage under the State Employee Group Insurance Program (SEGIP) are enrolled in a benefits program called the Minnesota Advantage Health Plan.

Advantage Plan features

The Minnesota Advantage Health Plan features include:

- Cost sharing features that will help you to better control your health care costs while maintaining flexibility in access to doctors and clinics.
- Uniform and comprehensive set of benefits across all plans.
- Out-of-pocket expense maximums for both prescription drugs and medical services to protect you from financial hardship.
- No copays charged for preventive care such as immunizations, annual check-ups, etc.
- Most medical care is coordinated through your Primary Care Clinic (PCC) and you will generally need a referral to see a specialist.
- You may self-refer to certain specialists including obstetricians/gynecologists, chiropractors, and mental health/chemical dependency practitioners. You may also self-refer for routine eye exams. Access to this specialty care still depends on your plan network and possibly your PCC.
- You may change your clinic and cost level as often as monthly.
- Referrals for office visits to a specialist are covered at the same benefit level as your PCC.
- We advise that you choose a plan that is available in the county in which you live.

Creditable coverage for prescription drugs

It has been determined that the prescription drug coverage offered through the Minnesota Advantage Health Plan is creditable. This means the amount that the Minnesota Advantage Health Plan expects to pay, on average, for prescription drugs is the same as or greater than what standard Medicare prescription drug coverage will pay. This is important because if you are now eligible or become eligible for Medicare Part D, but enroll at a future date, you will not pay extra for that coverage. A disclosure is available to you on the SEGIP website at: mn.gov/mmb/segip.

How does Advantage work?

Under Advantage, you will share in the cost of specific medical services you obtain by paying out-of-pocket costs (annual deductibles, office visit copays, coinsurance), similar to those paid by members of most employer-sponsored health benefit plans.

Health care providers have been placed into one of four cost levels. The cost level in which each provider is placed depends on the care system in which the provider participates and that care system's total cost of delivering health care. Participants pay the least out-of-pocket costs when using cost level 1 or 2 clinics.

Clinics may have changed cost levels for 2016. To check the cost level of your clinic, refer to the Advantage Clinic Directory on the SEGIP website at: mn.gov/mmb/segip.

To access, click on Open Enrollment tab. Then click on 2016 Advantage Clinic Directory or call your insurance carrier listed on page 23.

The amount of cost sharing that will be paid when using health care services varies depending on the cost level of the Primary Care Clinic that is chosen. Primary Care Clinics in the cost levels 1 and 2 provide the best value with the lowest possible out-of-pocket costs. Members in cost level 1 or 2 have annual out-of-pocket maximums set at the lowest amounts available under the plan: \$1,200 for single coverage and \$2,400 for family. Participants opting for coverage in a cost level 3 or 4 clinic will have higher out-of-pocket costs, as the delivery of care under these cost levels comes at a higher cost. Participants in cost level 3 will share in their cost of care up to the out-of-pocket maximum of \$1,600 single and \$3,200 family. Participants using cost level 4 clinics will share in the cost of their care to a maximum of \$2,600 single and \$5,200 family. Once you've reached your annual out-of-pocket maximum, the Advantage Plan will pay all remaining medical costs allowed under the plan for that year.

Navitus is the Pharmacy Benefits Manager for all participants of the Minnesota Advantage Health Plan regardless of the carrier selected. Under the SEGIP plan, most drugs are covered under one of three tiers, regardless of the PCC selected. The formulary may be accessed at www.navitus.com. The out-of-pocket maximum is the same, \$800 single and \$1,600 family, regardless of the cost level of a participant's Primary Care Clinic.

2016 Minnesota Advantage Health Plan Schedule of Benefits

2016 Benefit Provision	Cost Level 1 - You Pay	Cost Level 2 - You Pay	Cost Level 3 - You Pay	Cost Level 4 - You Pay
A. Preventive Care Services <ul style="list-style-type: none"> Routine medical exams, cancer screening Child health preventive services, routine immunizations Prenatal and postnatal care and exams Adult immunizations Routine eye and hearing exams 	Nothing	Nothing	Nothing	Nothing
B. Annual First Dollar Deductible (single/family)	\$150/300	\$250/500	\$ 550/1,100	\$1,250/2,500
C. Office visits for Illness/Injury, for Outpatient Physical, Occupational or Speech Therapy, and Urgent Care <ul style="list-style-type: none"> Outpatient visits in a physician's office Chiropractic services Outpatient mental health and chemical dependency Urgent Care clinic visits (in & out of network) 	\$25/30* copay per visit Annual deductible applies	\$30/35* copay per visit Annual deductible applies	\$60/65* copay per visit Annual deductible applies	\$80/85* copay per visit Annual deductible applies
D. In-network Convenience Clinics & Online Care (deductible waived)	\$10 copay	\$10 copay	\$10 copay	\$10 copay
E. Emergency Care (in or out of network) <ul style="list-style-type: none"> Emergency care received in a hospital emergency room 	\$100 copay Annual deductible applies	\$100 copay Annual deductible applies	\$100 copay Annual deductible applies	25% coinsurance Annual deductible applies
F. Inpatient Hospital Copay (waived for admission to Center of Excellence)	\$100 copay Annual deductible applies	\$200 copay Annual deductible applies	\$500 copay Annual deductible applies	25% coinsurance Annual deductible applies
G. Outpatient Surgery Copay	\$60 copay Annual deductible applies	\$120 copay Annual deductible applies	\$250 copay Annual deductible applies	25% coinsurance Annual deductible applies
H. Hospice and Skilled Nursing Facility	Nothing	Nothing	Nothing	Nothing
I. Prosthetics, Durable Medical Equipment	20% coinsurance	20% coinsurance	20% coinsurance	25% coinsurance Annual deductible applies
J. Lab (including allergy shots), Pathology, and X-ray (not included as part of preventive care and not subject to office visit or facility copayments)	5% coinsurance Annual deductible applies	5% coinsurance Annual deductible applies	20% coinsurance Annual deductible applies	25% coinsurance Annual deductible applies
K. MRI/CT Scans	5% coinsurance Annual deductible applies	10% coinsurance Annual deductible applies	20% coinsurance Annual deductible applies	25% coinsurance Annual deductible applies
L. Other expenses not covered in A-K above, including but not limited to: <ul style="list-style-type: none"> Ambulance Home Health Care Outpatient Hospital Services (non-surgical) <ul style="list-style-type: none"> Radiation/chemotherapy Dialysis Day treatment for mental health and chemical dependency Other diagnostic or treatment related outpatient services 	5% coinsurance Annual deductible applies	5% coinsurance Annual deductible applies	20% coinsurance Annual deductible applies	25% coinsurance Annual deductible applies
M. Prescription Drugs 30-day supply of Tier 1, Tier 2, or Tier 3 prescription drugs, including insulin, or a 3-cycle supply of oral contraceptives Note: all Tier 1 generic and select branded oral contraceptives are covered at no cost.	\$14/25/50	\$14/25/50	\$14/25/50	\$14/25/50
N. Plan Maximum Out-of-Pocket Expense for Prescription Drugs (excludes PKU, Infertility, growth hormones) (single/family)	\$800/1,600	\$800/1,600	\$800/1,600	\$800/1,600
O. Plan Maximum Out-of-Pocket Expense (excluding prescription drugs) (single/family)	\$1,200/2,400	\$1,200/2,400	\$1,600/3,200	\$2,600/5,200

*The level of the office visit copayment for the employee and his or her family is dependent upon whether the employee has completed the Health Assessment in each Open Enrollment period, and agreed to accept a health coach call. Employees who have completed the Health Assessment and accept a health coaching call are entitled to the lower copayment. Employees hired after the close of Open Enrollment will be entitled to the lower copayment.

This chart applies only to in-network coverage. Point-of-Service (POS), coverage is available only for members whose permanent residence is outside the State of Minnesota and outside the service areas of the health plans participating in Advantage. This category includes employees temporarily residing outside Minnesota on temporary assignment or paid leave [including sabbatical] and college students. It is also available to dependent children and spouses permanently residing outside the service area. These members pay a \$350 single or \$700 family deductible and 30% coinsurance to the out-of-pocket maximum described in Section O above. Members pay the drug copayment described at Section M above to the out-of-pocket maximum described at Section N. This benefit must be requested.

A standard set of benefits is offered in all SEGIP Advantage Plans. There are still some differences from plan to plan in the way that benefits, including the transplant benefit, are administered, in the referral and diagnosis coding patterns of primary care clinics, and in the definition of Allowed Amount.

Benefits for Palliative Care are fully described in the Advantage Summary of Benefits.

Coordinated Plan *(age 65 and over)*

This is a BlueCross BlueShield of Minnesota Plan available for those who are:

- Age 65 and older.
- Enrolled in Medicare Parts A and B.
- Enrolled in Medicare Part D which is included with this plan.

Requires immediate completion and return of forms to the plan. There are two forms entitled, “Enrollment Form for State of Minnesota Coordinated Plan” and, “Group MedicareBlueRx (PDP).” Forms will be mailed directly to your home address.

General plan features

The Coordinated Plan is available in all Minnesota counties and worldwide.

As a member of the Coordinated Plan, you are free to choose any health care provider. However, when you use providers that participate with BlueCross BlueShield Plans (BCBS), your claims will be filed for you and the BCBS payment will be made directly to the provider. In addition, BCBS providers have agreed to accept the allowed amount as payment in full. You are only responsible for any deductible, coinsurance, and copayments for eligible services.

Health care providers who do not participate with BCBS may charge more for services than the allowed amount. When you use a provider who does not participate with BCBS you are responsible for the deductible, copayments or coinsurance and any eligible charges that exceed the allowed amount. You may also have to file your own claims.

Some deductibles specified in the Coordinated Plan are based on 2015 Medicare deductibles which are subject to change through action by the federal government for 2016. Be aware that such changes could take place without warning.

Inpatient admissions

Inpatient services:

- General hospital
- Skilled nursing facilities
- Mental health
- Chemical dependency

The Coordinated Plan will process at 80% of the first \$3,000 of total eligible expenses, then 100% for a semi-private room up to 365 days, following your \$200 annual deductible.

- **Deductible:** A deductible applies to the first \$200.
- **Coinsurance:** After the \$200 inpatient deductible, each participant is responsible for 20% of the first \$3,000 (\$600) of the total eligible expenses.
Eligible expenses in excess of \$3,000 each calendar year are covered at 100%.
- **Inpatient services out-of-pocket maximum:** \$800 per participant per calendar year (\$200 deductible plus 20% of the next \$3,000).

Coordinated Plan *(age 65 and over)*

Emergency services

- After the Medicare Part B annual deductible, 100% coverage. The plan requires participants to pay the 2016 Medicare Part B deductible as indicated by Medicare (the Part B deductible is \$147.00 for plan year in 2015 and is subject to change for 2016).

Health care services

There is an annual outpatient deductible for all medical (Medicare Part B) services. After the deductible is met, services will be covered as follows.

- **Preventive care:** 100% coverage. Preventive care is not subject to the deductible.
- **Physician services:** 100% coverage.
- **Eye and hearing exams:** One routine exam per calendar year. 100% coverage of the allowed amount. The Medicare Part B deductible does not apply.
- **Hospital outpatient and surgery center:** 100% coverage.
- **Outpatient mental health services:** 100% coverage.
- **Outpatient chemical dependency services:** 100% coverage.
- **Chiropractic services:** 100% coverage.
- **Physical, speech, and occupational therapy (in an outpatient hospital):** 100% coverage.
- **Home health care:** 100% of the Medicare-approved amount for medically necessary skilled care.

Prescriptions and products

Prescription Drugs: 30-day supply, including insulin.

- **\$10 copayment** for generic drugs.
- **\$30 copayment** for preferred brand drugs.
- **\$50 copayment** for brand name drugs.
- **\$50 copayment** for specialty.
- **25% coinsurance** for supplemental drugs. These are certain classes of drugs not covered by Medicare.
- SEGIP Retirees pay the appropriate copay while in the donut hole or gap. SEGIP Retirees do **NOT** pay a greater percent of drug costs while in the donut hole.
- **Catastrophic prescription drug coverage:** If out-of-pocket expenses total \$4,850 the prescription drug copay reduces to the greater of 5% coinsurance or a \$2.95 copay for generics (including brand drugs treated as generic) and \$7.40 for other drugs for the remainder of the year.
- **Mail Order/Preferred Extended Supply:** (90-day supply). Generic Drugs - \$20 copay, Preferred Brand Drugs - \$60 copay, Non-Preferred Brand Drugs - \$100 copay, Specialty Drugs - \$100 copay.

Prosthetics and durable medical equipment:

- 100% coverage after the annual Medicare Part B deductible.
- **Hearing aids** 80% coverage for hearing aids and accessories every three years. Must be purchased at a BCBS approved provider. Check the Summary for more information.

Fitness Program

- BlueCross Fitness Discount program

HealthPartners Freedom Plan (age 65 and over)

This is a HealthPartners Freedom Plan available for those who are:

- Age 65 and older
- Enrolled in Medicare Parts A and B
- Must enroll in Medicare Part D which is included with this plan.

Requires immediate completion and return of forms to the plan. The form is entitled “2016 Freedom Group Plan (Cost) Enrollment Instructions for Group Enrollees.” Forms will be mailed directly to your home address.

General plan features

Health care services are provided through the HealthPartners Freedom Plan network of physicians, clinics, pharmacies, and other health care providers. HealthPartners Freedom Plan is available in all Minnesota counties and some of the counties in western Wisconsin (listed on page 10 of this book).

When you join the HealthPartners Freedom Plan with the open access network, you do not need to select a Primary Care Clinic and you may see any medical provider listed in the network without a referral.

To get the highest level of coverage, health services must be provided or arranged by a network physician except for emergencies, out-of-area urgently needed care, or as covered by the extended absence benefit. If you get routine care from out-of-network providers without activating your extended absence benefit, you will still be able to use your original Medicare benefits when obtaining care outside the plan's network but will be responsible for Medicare deductibles, coinsurance, and any additional charges not covered by Medicare.

Extended absence benefit

- In-network benefits while you are outside of Minnesota in the United States for up to nine months annually.
- Must call HealthPartners to activate this benefit.

Inpatient admissions

- **General hospital:** \$100 copay and then 100% coverage for unlimited days.
- **Skilled nursing facilities:** 100% coverage for rehabilitative care after 3 days prior hospitalization for up to 100 days per benefit period. You must meet current Medicare coverage requirements. Requires preauthorization by HealthPartners.
- **Mental health:** \$100 copay and then 100% coverage for unlimited days.
- **Chemical dependency:** \$100 copay and then 100% coverage for unlimited days.

Emergency services

- **In the HealthPartners Freedom service area:** \$50 copay for emergency services. \$100 copay if admitted into a hospital. 100% coverage for ambulance services.
- **Outside the HealthPartners Freedom service area:** \$50 copay for emergency services. 80% coverage outside of the United States.

HealthPartners Freedom Plan (age 65 and over)

Health care services

There is a \$3,400 out-of-pocket maximum expense for health care services.

- **Preventive care:** 100% coverage.
- **Physician services:** \$10 copay then 100% coverage. (\$10 copay does not apply to nutritional therapy for diabetics.)
- **Eye and hearing exams:** 100% coverage. Referral from primary care physician unnecessary.
- **Hospital outpatient and surgery center:** 100% coverage.
- **Outpatient mental health services:** \$10 copay then 100% coverage; \$5 copay for group therapy.
- **Outpatient chemical dependency services:** \$10 copay then 100% coverage.
- **Chiropractic services:** \$10 copay then 100% coverage.
- **Physical, speech, and occupational therapy:** 100% coverage for physical and occupational therapy. Speech therapy is a \$10 copay then 100% coverage.
- **Home health care:** 100% coverage. Must meet Medicare guidelines.
- **Online Care:** 100% coverage for unlimited online care visits at virtuwell.com.

Prescriptions and products

Prescription drugs: 30-day supply

- **\$10 copay** for generic brand and preferred generic.
- **\$30 copay** for preferred brand.
- **\$50 copay** for non-preferred brand.
- **\$50 copay** per prescription for specialty drugs.
- SEGIP Retirees pay the appropriate copay while in the donut hole or gap. SEGIP Retirees do **NOT** pay a greater percent of drug costs while in the donut hole.
- **Catastrophic prescription drug coverage:** If you reach the catastrophic level of \$4,850, then the defined benefit will be the Part D level of \$2.95 generic or preferred brand and the lesser of 5% or \$7.40 for all other drugs but not higher than the initial coverage level benefit of \$10 generic/\$30 preferred brand/\$50 non-preferred brand/\$50 specialty.
- **Mail order prescription options:** \$20 copay for a 90-day supply of formulary generic drugs; \$60 for a 90-day supply of formulary brand name drugs; \$100 for a 90-day supply of non-preferred brand drugs.

Prosthetics and durable medical equipment:

- 90% coverage, **including test strips for people with diabetes.** (No more than a 90-day supply will be covered and dispensed at a time.)
- 80% coverage for hearing aids and accessories every three years.

Fitness Program:

- Silver & Fit

UCare for Seniors *(age 65 and over)*

This plan is available for those moving from PreferredOne to the UCare for Seniors Plan. This is for those who are:

- Age 65 and older.
- Enrolled in Medicare Parts A and B.
- Enrolled in Medicare Part D which is included with this plan.

Requires immediate completion and return of forms to the plan. The form is entitled, "UCare for Seniors Group Enrollment Request Form." Forms will be mailed directly to your home address.

General plan features

Health care services are provided through UCare for Seniors' network of physicians, clinics, pharmacies, and other health care providers. UCare for Seniors is available in all counties in Minnesota and 26 western Wisconsin counties listed on page 10 of this booklet.

Referrals are not needed for specialty care. UCare also provides coverage for services obtained outside the UCare for Seniors' network. This coverage is offered at a reduced benefit level.

As a UCare for Seniors member, you select the clinic of your choice. Family members may choose different clinics. **See Point of Service below.**

Point of Service

- Routine and non-emergency physician services outside of the UCare for Seniors network in the United States are covered at 80% to a maximum benefit of \$100,000. The participant pays 20% to a maximum out-of-pocket of \$10,000 for eligible expenses per calendar year. The participant would be responsible for all charges above \$100,000.

Inpatient admissions

- **General hospital:** 100% coverage after a \$100 copay per admission.
- **Skilled nursing facilities:** 100% coverage for rehabilitative care up to 100 days. Must meet current Medicare coverage requirements. No 3-day hospitalization stay required.
- **Mental health:** 100% coverage, after a \$100 copay per admission.
- **Chemical dependency:** 100% coverage.

Emergency/urgent care services

- In and out of area emergencies: \$50 copayment, 100% coverage thereafter. Copay waived upon hospital admission.
- Urgent care: \$20 copayment, 100% coverage thereafter.
- Ambulance: 100% coverage after \$100 copay

UCare for Seniors *(age 65 and over)*

Health care services

There is a **\$3,400 out-of-pocket maximum expense for in-network health care services.**

- **Preventive care:** 100% coverage.
- **Physician services:** 100% coverage after a \$15 copay per visit.
- **Eye and hearing exams:** 100% coverage.
- **Hospital outpatient and surgery center:** 100% coverage.
- **Outpatient mental health services:** 100% coverage after a \$15 copay per visit.
- **Outpatient chemical dependency services:** 100% coverage after a \$15 copay per visit.
- **Chiropractic services:** 100% coverage for Medicare-approved services. Must use a UCare for Seniors affiliated chiropractor.
- **Physical, speech, and occupational therapy (in an outpatient hospital):** 100% coverage after a \$15 copay per visit.
- **Home health care:** 100% coverage for skilled care.

Prescriptions and products

Prescription drugs: 30-day supply

- **\$10 copayment** for generic drugs.
- **\$30 copayment** per prescription for preferred brand name drugs.
- **\$50 copayment** per prescription for brand name drugs.
- **\$50 copayment** for specialty drugs.
- SEGIP Retirees pay the appropriate copay while in the donut hole or gap. SEGIP Retirees do **NOT** pay a greater percent of drug costs while in the donut hole.
- **Mail order and at local pharmacies (90-day supply):** \$20 copayment for generic drugs; \$60 copayment for preferred brand name drugs; \$100 copayment for other brand name or specialty drugs for maintenance drugs otherwise three (3) copays apply.
- **Catastrophic prescription drug coverage:** If out-of-pocket expenses total \$4,850 the prescription drug copay reduces to the greater of 5% coinsurance or a \$2.95 copay for generics (including brand drugs; treated as generic) and \$7.40 for other drugs for the remainder of the year.

Prosthetics, durable medical equipment and diabetic supplies:

- 100% coverage for prosthetics.
- 80% coverage for durable medical equipment.
- \$500 toward hearing aid purchase once every 36 months.
- \$75 toward eyeglass frames and lenses once each calendar year.
- 100% coverage for Part B diabetic supplies - Syringes and insulin covered as prescription drugs.

Fitness Program:

- SilverSneakers®
- UCare Health Club Savings Program

Comparison Chart for Senior Plans

2016 Benefit	Coordinated Plan	Freedom Plan	UCare for Seniors
Extended Absence or Point of Service	Worldwide coverage	Network benefits outside MN (in USA) up to 9 months	Worldwide coverage for emergencies. 80% coverage for non-emergencies anywhere in the U.S. May be outside service area for up to 6 months.
Inpatient Admissions General Hospitalization	\$200 deductible + 20% of the first \$3000 (\$600) = \$800 per patient per calendar year	\$100 copay per admission, then 100% coverage.	\$100 copay per admission, then 100% coverage. See limitation on skilled nursing.
Emergency Services	After Medicare B annual deductible, 100% coverage	\$50 copay or \$100 copay if admitted to hospital.	\$50 copay. \$100 copay if admitted to hospital.
Out of Pocket Maximum	\$800 inpatient, Medicare B deductible and 20% on hearing aids	\$3,400	\$3,400
Preventative care	100% Coverage (no deductible)	100% Coverage	100% Coverage
Eye & Hearing Exam	100% (no deductible) for one routine exam per year	100% Coverage	100% Coverage
Physicians Service	Medicare B deductible, then 100%	\$10 copay, then 100% coverage	\$15 copay, then 100% coverage
Inpatient Hospitalization	\$200 deductible plus 20% of \$3,000 (600) which is \$800 per patient per year.	\$100 copay per admission, then 100% coverage. See limits on skilled nursing, mental health and chemical dependency.	\$100 copay per admission, then 100% coverage. See limitation on skilled nursing.
Hospital Outpatient and Surgery Center	After Medicare B annual deductible, 100% coverage	100% Coverage	100% Coverage
Outpatient Mental Health	After Medicare B annual deductible, 100% coverage	\$10 copay or \$5 copay for group then 100% Coverage	\$15 copay per visit, then 100% coverage
Outpatient Chemical Dependency	After Medicare B annual deductible, 100% coverage	\$10 copay, then 100% coverage	\$15 copay per visit, then 100% coverage
Chiropractic	After Medicare B annual deductible, 100% coverage	\$10 copay, then 100% coverage	100% Coverage for medical approved services with UCare for Seniors Chiropractor.
Physical Therapy	After Medicare B annual deductible, 100% coverage	100% Coverage	100% coverage outpatient setting, after \$15 copay per visit
Occupational Therapy	After Medicare B annual deductible, 100% coverage	100% Coverage	100% coverage outpatient setting, after \$15 copay per visit
Speech Therapy	After Medicare B annual deductible, 100% coverage	\$10 copay, then 100%	100% Coverage outpatient setting after \$15 copay per visit
Home Health –skilled care meeting Medicare approved guidelines	After Medicare B annual deductible, 100% coverage	100% Coverage	100% Coverage
30-day Prescriptions	\$10 Generic	\$10 Generic	\$10 Generic
	\$30 Preferred Brand	\$30 Brand Formulary	\$30 Preferred Brand Name
	\$50 Brand Name	\$50 Non Preferred Brand	\$50 Brand Name
	\$50 for Specialty drugs	\$50 for Specialty drugs	\$50 for Specialty drugs
	25% for supplementary drugs	n/a	Supplemental Rx Covered
Mail Order Available	Yes	Yes	Yes
Prosthetics	100% after the annual Medicare B deductible	90%	100%
Durable Medical Equipment	100% after the annual Medicare B deductible	90% including test strips for diabetics	80% and 100% for Part B diabetic supplies
Hearing Aid	80% for hearing aids and accessories purchased at BCBS providers every 3-yr	80% for hearing aids and accessories every 3-yr	\$500 reimbursement every 36-months at any vendor
Eye Glasses	eyewear discounts available	eyewear discounts available	\$75 allowance toward eyewear per year

Other information

Health Plan addresses and phone numbers

Carrier	Address	Phone Numbers
Minnesota Advantage Health Plan - BlueCross BlueShield, Coordinated Plan	BlueCross BlueShield of Minnesota P.O. Box 64560 St. Paul, MN 55164-9756 www.bluecrossmn.com/segip	1-800-262-0819 651-662-5090 1-888-878-0137 - TTY
Medicare Blue RX	www.YourMedicareSolutions.com	1-877-838-3827 1-866-213-9296 - TTY
National PPO for Advantage - Blue Cross Blue Card	www.bluecrossmn.com/segip	1-800-810-2583
Minnesota Advantage Health Plan - HealthPartners	HealthPartners Attn: Membership Accounting P.O. Box 297 Minneapolis, MN 55440-0297 www.healthpartners.com/segip	952-883-7900 1-888-343-4404 952-883-5127-TTY
HealthPartners Freedom Plan	HealthPartners Attn: Medicare Sales 8170 33rd Ave S, MS21102A Bloomington, MN 55425 www.healthpartners.com/segipmedicare	952-883-7979 1-800-233-9645 1-800-443-0156 - TTY
National PPO for Advantage - HealthPartners	CIGNA Attn: Membership Accounting P.O. Box 297 Minneapolis, MN 55440-0297 www.healthpartners.com/segip	1-888-343-4404
Minnesota Advantage Health Plan - PreferredOne	PreferredOne Administrative Services 6105 Golden Hills Drive Golden Valley, MN 55416 www.preferredone.com/segip	763-847-4477 1-800-997-1750 763-847-4013 - TTY
National PPO for Advantage - PreferredOne	Multiplan PHCS www.multiplan.com	1-866-241-7427
UCare for Seniors	UCare Attn: Group UCare for Seniors 500 Stinson Boulevard NE Minneapolis, MN 55413 Groupsales@ucare.org www.ucare.org	612-676-6900 1-877-598-6574 612-676-6810 – TTY 1-800-688-2534 - TTY
Navitus Health Solutions	Navitus P.O. Box 999 Appleton, WI 54912-0999 www.navitus.com	1-866-333-2757 1-920-225-7005-TTY

Carrier	Address	Phone Numbers
Eide Bailly for HRA and Benny Card	Eide Bailly Employee Benefits (SEGIP Pre-tax Plans) www.eidebaillybenefits.com/som	612-253-6633 1-800-300-1672
CNA Long Term Care Insurance	www.mpel.org	1-888-653-9600 877-914-2358 - Fax
Employee Insurance Division, State Employee Group Insurance Program MMB	MMB - Employee Insurance Division 400 Centennial Office Building 658 Cedar Street St. Paul, MN 55155 mn.gov/mmb/segip	651-355-0100 800-664-3597 651-296-5445 - Fax
Medicare	medicare.gov	1-800-MEDICARE (1-800-633-4227) 1-877-468-2048 - TTY/TDD
Social Security	www.socialsecurity.gov	1-800-772-1213 1-800-325-0778 - TTY

Exclusive Retiree Open Enrollment Meetings

No registration is required. Questions about meetings should be directed to MMB.

Date	Time	Location
October 27, 2015	10:00 a.m. - 12:00 noon	MnDOT- Northwoods Rivercenter Rooms 2151 Bassett Drive Mankato, MN 56001
October 28, 2015	10:00 a.m. - 12:00 noon	MSRS Building, Room 106* 60 Empire Drive St. Paul, MN 55103
October 29, 2015	1:00 p.m. - 3:00 p.m.	Rochester Public Library 101 Second St SE Rochester, MN 55904
October 30, 2015	10:00 a.m. - 12:00 noon	Southdale Public Library 7001 York Avenue South Edina, MN 55435
November 2, 2015	10:00 a.m. - 12:00 noon	MSRS Building, Room 106* 60 Empire Drive St. Paul, MN 55103
November 3, 2015	10:00 a.m. - 12:00 noon	Brainerd Fire Department 23 Laurel Street Brainerd, MN 56401
November 4, 2015	10:00 a.m. - 12:00 noon	Mn DOT-Duluth 1123 Mesaba Avenue Duluth, MN 55811

* MSRS has free parking available on the third level of the parking ramp. You may enter the building from the ramp on the third floor and take the elevator down to the first floor.

Glossary

Allowed amount: A set amount which an insurance company (often referred to as a plan) agrees to pay for a particular service or product provided by a doctor or health care provider. Under some plans, there may be a difference in the insurance company's allowed amount and the health care provider's fee for a particular service or product. In some of these cases, the insured person is responsible for paying the difference.

Benny Card: A debit card that allows you to pay for qualified health care expenses via a tax favored expense account and/or Health Reimbursement Arrangement (HRA).

Brand name drugs: Prescription drugs that are sold under a trade marked brand name.

Carrier: An organization, such as an insurance company, that provides or administers programs that arrange for health, life or other insurance services. All of the companies that offer health, dental, life, and optional insurance plans through the State Employee Group Insurance Program may be called carriers.

Certificate of coverage: A document available to plan participants describing details of coverage. Insured plans call this a certificate of coverage and self-insured plans call this a summary of benefits.

Coinsurance: This is a percentage of the cost that is charged for certain services after the deductible has been paid. For example, a coinsurance level of 90% means that the member first pays the deductible, then the plan would pay 90% of the costs and the member would pay the remaining 10% of the costs. Once the employee costs reach the out-of-pocket limit, the plan would pay all costs for the rest of the plan year.

Copayment (or copay): A flat dollar amount that is charged every time a service is provided. For example, under Advantage, members will be charged an office visit copay for most visits to the doctor's office. (Copays will not be charged for preventive care under Advantage, such as immunizations, annual check-ups, etc.)

Creditable coverage: Prescription drug coverage that is on average at least as good as the standard Medicare prescription drug coverage.

Deductible: An annual amount that must be paid each year before the plan starts paying for services. A "\$100 deductible" for example, means that the member would pay the first \$100 per year for certain services before the plan would begin covering the cost of services.

Dependent: Generally, the spouse/children of a covered person, as defined in the insurance policy or plan.

Effective date: The date on which an insurance policy or plan goes into effect and coverage begins.

Eligible expenses: Medical expenses for which a health plan will provide benefits. Some health providers may charge more than what an insurance plan considers eligible. In these cases, the covered person is responsible for paying the additional costs.

Family coverage: Health insurance for the retiree and eligible dependents.

Formulary: A drug formulary is a listing of preferred high-quality, cost-effective drugs selected by a professional committee of physicians and pharmacists.

Generic: A drug that has been on the market long enough that no single manufacturer has an exclusive right on making and marketing.

Health Reimbursement Arrangement (HRA): This is an employer funded account that reimburses participants for certain medical-dental expenses not covered under the health plan.

In-network: The group of health care providers with whom a plan has contracted to provide services to members of the plan. Networks may change during the year, so ask if a provider is still participating with your plan before you seek services.

Medicare: The federal government's plan for paying certain hospital and medical expenses for those individuals who qualify for and are enrolled in the Medicare plan, primarily those 65 and over. Benefits are provided regardless of income level. The program is government-subsidized and government-operated.

Medicare Part A: Medicare Part A, hospital insurance, pays for inpatient hospital services and post-hospital care.

Medicare Part B: Medicare Part B, Supplementary Medical Insurance, pays for medically necessary doctors' services, outpatient hospital services, and other medical services and supplies not covered by Part A.

Medicare Part D: Medicare Part D pays for prescription drug coverage for qualified Medicare beneficiaries.

Open Enrollment: The period during which participants in the State Employee Group Insurance Program have an opportunity to change from one plan to another.

Out-of-pocket costs: Fees and charges that an insured person is required to pay for products or services.

Outpatient services: Treatment that does not require hospitalization.

Over the Counter (OTC): a class or group of medications or durable medical goods used to alleviate or treat personal injuries or sickness. Any OTC items that are not medically necessary are not reimbursable. Please see the specific list of OTC items on the Eide Bailly website at www.eidebaillybenefits.com/som.

The Patient Protection and Affordable Care Act (PPACA): A federal statute that was signed into law in the United States on March 23, 2010. The law includes numerous health-related provisions to take effect over a four-year period, including expanding Medicaid eligibility, subsidizing insurance premiums, providing incentives for businesses to provide health care benefits, prohibiting denial of coverage/claims based on pre-existing conditions, establishing health insurance exchanges, and support for medical research.

Preferred brand: A group of brand name drugs that the pharmacy benefit manager has selected to be the most effective for the price.

Preferred Provider Organization (PPO): A group of physicians and hospitals that contract with an insurance company to provide medical services.

Prescription Drug Plan (PDP): Private risk-bearing entity providing stand-alone Medicare Part D coverage.

Primary care: Routine medical care, normally provided in a doctor's office, by an internist, family or general practitioner, obstetrician-gynecologist, osteopath or pediatrician.

Provider: A doctor, therapist, chiropractor or other licensed medical practitioner. A participating provider is a provider who contracts with a plan to provide services to members of the health or dental insurance plan.

Summary of Benefits: A document available to plan participants describing details of coverage. Insured plans call this a certificate of coverage and self-insured plans call this a summary of benefits.

Minnesota Management & Budget Notice of Collection of Private Data

Minnesota Management & Budget (MMB) administers the State Employee Group Insurance Program (SEGIP). This notice explains why we are requesting the private data about you, your spouse, and dependents, how we will use it, who will see it, and your obligation to provide the data.

What data will we use?

We will use the data you provide us at this time, as well as data previously provided us, about yourself, your spouse, or dependent(s). If you provide any data about that is not necessary, we will not use it for any purpose.

SEMA4, the information system used to administer employee benefits, contains required information fields that may not be necessary for us to process your request. We only need your dependent's date of death to process a death benefit claim or to discontinue the dependent's coverage due to his or her death. Disability status is needed only to determine eligibility for insurance continuation for your dependent. We need the social security numbers and birth dates of your spouse and dependents to offer insurance continuation, process a death benefit, to ensure we are matching them to the correct insurance benefit transaction and to comply with federal Medicare coordination laws.

Why we ask you for this data?

We ask for this data so that we can successfully administer SEGIP.

This data is used to process your request to add or change coverage for yourself, your spouse, or dependents. The requested data helps us to determine eligibility, to identify you and your spouse, and dependents, and to contact you or your spouse, and dependents. The data is also used to develop new programs, ensure current programs effectively and efficiently meet member needs, and to comply with federal and state law and rules. We may ask for data about you, your spouse or dependents that we have already collected, including all or part of your social security number, in order to ensure we are matching you to the correct insurance benefit transaction. We need the social security numbers and birth dates of your spouse and dependent to offer insurance continuation, process a death benefit, to ensure we are matching them to the correct insurance benefit transaction and to comply with federal Medicare coordination laws (in compliance with Section 111 of the Medicare, Medicaid, and SCHIP Extension Act of 2007 (P.L. 110-173)). If you provide any data about you, your spouse, or dependents that is not necessary, we will not use it for any purpose.

Do you have to answer the questions we ask?

You are not required to provide all of the data but certain data must be collected. If you do not provide the requested data, your dependent(s) may not be approved to participate in the program or may lose coverage under the program. If you do provide the data, it will be used as described.

What will happen if you do not answer the questions we ask?

If you do not answer these questions, the insurance benefit transaction you requested for you or your spouse, dependent or other insurance benefit transaction may be delayed or denied.

Who else may see this data about you and your spouse and dependents?

We may give data about you and your spouse, and dependents to the insurance carrier you have chosen, SEGIP's other representatives, vendors and actuary; the Legislative Auditor; the Department of Health; the Department of Commerce; and any law enforcement agency or other agency with the legal authority to have the data; and anyone authorized by a court order. In addition, the parents of a minor may see data on the minor unless there is a law, court order, or other legally binding instrument that blocks the parent from that data.

How else may this data be used?

We can use or release this data only as stated in this notice unless you give us your written permission to release the data for another purpose or to release it to another individual or entity. The data may also be used for another purpose if Congress or the Minnesota Legislature passes a law allowing or requiring us to release the data or to use it for another purpose.

Upon request, this guide can be provided in alternative by calling (651) 355-0100.



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